WOMEN' & MEN'S HEALTH PROGRAMS

Fee for Service Schedule – REVISED 10-2014

Effective July 1, 2014 through June 30, 2015

REVISED rates are in RED

OFFICE VISITS			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**END NOTES**
New Patient; history, exam, straightforward decision-making; (10 min. face-to-face)	99201	$40.08	
	99201 *	$24.83	
New Patient Office Visit for STD testing only (men and women) ***State Pap Plus Program***	99201	$25.00	1
New Patient; *expanded* history, exam, straightforward decision-making; (20 min. face-to-face)	99202	$69.22	
	99202 *	$47.48	
New Patient Office Visit for STD testing only (men and women) ***State Pap Plus Program***	99202	$25.00	1
New Patient; *detailed* history, exam, straightforward decision-making; (30 min. face-to-face)	99203	$100.17	
	99203 *	$71.93	
New Patient; *comprehensive* history, exam, decision-making of moderate complexity (45 min. face-to-face)	99204	$100.17	2
	99204 *	$71.93	
New Patient; *comprehensive* history, exam, decision-making of moderate complexity (60 min. face-to-face)	99205	$100.17	2
	99205 *	$71.93	
Established Patient; history, exam, straightforward decision-making; (5 min. face-to-face)	99211	$18.58	
	99211 *	$ 8.84	
Established Patient *expanded* history, exam, straightforward decision-making; (10 min. face-to-face)	99212	$40.40	
	99212 *	$23.85	
Established Patient Office Visit for STD testing only (men & women) ***State Pap Plus Program***	99212	$25.00	1
Established Patient *detailed* history, exam, straightforward decision-making; (15 min. face-to-face)	99213	$68.06	
	99213 *	$48.59	
Established Patient *detailed* history, exam, decision-making of moderate complexity; (25 min. face-to-face)	99214	$68.06	3
	99214 *	$48.59	
Established Patient; *comprehensive* history, exam, decision-making of high complexity; (40 min. face-to-face)	99215	$68.06	3
	99215 *	$48.59	
Consultation; history, exam, straightforward decision-making; (15 min. face-to-face)	99241	$68.06	3
	99241 *	$48.59	
Consultation; Patient *expanded* history, exam, straightforward decision-making; (30 min. face-to-face))	99242	$100.17	2
	99242 *	$71.93	
Consultation; *detailed* history, exam, decision-making of low complexity; (40 min. face-to-face)	99243	$100.17	2
	99243 *	$71.93	
Consultation; *comprehensive* history, exam, decision-making of moderate complexity; (60 min. face-to-face)	99244	$100.17	2
	99244 *	$71.93	
New Patient Office Visit - ***State Pap Plus Program Only*** Only payable when client has eligible Pap according to program guidelines	99385	$68.06	1 4
New Patient; *Initial* comp. prev. med. evaluation & management; history, exam, counseling/guidance, risk factor reduction, ordering of appropriate lab procedures, etc. (Age 40-64) (Age 50 for NCP due to Age Guidelines)	99386	$100.17	2
	99386 *	$71.93	
New Patient Comprehensive (Age 65 & Older – without Medicare B)	99387	$100.17	2
	99387 *	$71.93	
Established Comprehensive Preventive Medicine (Age 18-39)	99395	$68.06	3
	99395 *	$48.59	
Established Patient - ***State Pap Plus Program Only*** Only payable when client has eligible Pap according to program guidelines	99395	$68.06	1 3
Established Comprehensive Preventive Medicine (Age 40-64) (Age 50 for NCP due to Age Guidelines)	99396	$68.06	3
	99396 *	$48.59	
Established Comprehensive Preventive Medicine; (Age 65 and Older–without Medicare B) (Age 50 for NCP due to Age Guidelines)	99397	$68.06	3
	99397 *	$48.59	

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WOMEN' & MEN'S HEALTH PROGRAMS

Fee for Service Schedule – REVISED 10-2014

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BREAST SCREENING & DIAGNOSTIC PROCEDURES			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**END NOTES**
Fine needle aspiration; without imaging guidance, Breast	10021	$136.35	
	10021 *	$65.92	
Fine needle aspiration; with imaging guidance, Breast	10022	$129.52	
	10022 *	$62.67	
Puncture Aspiration of cyst of Breast	19000	$103.17	
	19000 *	$41.50	
Puncture Aspiration of cyst of Breast; each additional cyst (use in conjunction with 19000)	19001	$25.07	
	19001 *	$20.53	
Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance.	19081	$614.28	5
	19081 *	$166.07	
Each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure) (Use 19082 in conjunction with 19081)	19082	$499.87	5
	19082 *	$81.52	
Biopsy, breast, with placement of breast localization device(s)(eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance.	19083	$610.84	5
	19083 *	$156.14	
Each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure) (Use 19084 in conjunction with 19083)	19084	$493.12	5
	19084 *	$76.72	
Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance.	19085	$925.98	5
	19085 *	$182.75	
Each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure) (Use 19086 in conjunction with 19085)	19086	$745.23	5
	19086 *	$87.68	
Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure) (ASC Group 1)	19100	$136.19	
	19100 *	$63.49	
Biopsy of breast; open, incisional/ABBI (ASC Group 2)	19101	$307.25	
	19101 *	$200.79	
Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion, nipple or areola lesion; open; one or more lesions (except 19140) (ASC Group 3)	19120	$445.85	
	19120 *	$374.77	
Excision of breast lesion identified by preoperative placement of radiological marker; single lesion (ASC Group 3)	19125	$494.21	
	19125 *	$416.00	
Each additional lesion *separately identified by a preoperative radiological marker* (Use in conjunction with 19125) (ASC Group 3)	19126	$147.04	
Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance.	19281	$225.54	6
	19281 *	$97.99	
Each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure) (Use 19282 in conjunction with 19281)	19282	$157.25	6
	19282 *	$48.20	
Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance.	19283	$255.72	6
	19283 *	$98.96	
Each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure) (Use 19284 in conjunction with 19283)	19284	$188.08	6
	19284 *	$48.52	
Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance.	19285	$430.25	6
	19285 *	$83.96	
Each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure) (Use 19286 in conjunction with 19285)	19286	$360.89	6
	19286 *	$41.53	
Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance.	19287	$790.04	6
	19287 *	$129.89	

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WOMEN' & MEN'S HEALTH PROGRAMS

Fee for Service Schedule – REVISED 10-2014

Effective July 1, 2014 through June 30, 2015

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BREAST SCREENING & DIAGNOSTIC PROCEDURES - CONTINUED			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**END NOTES**
Each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure) (Use 19288 in conjunction with 19287)	19288	$634.44	6
	19288 *	$62.25	
Screening mammogram, Digital, Bilateral; ***(patient must be age 40)***	G0202	$123.70	7
	G0202-TC	$90.02	
	G0202-26	$33.68	
Diagnostic Mammogram, Digital, Bilateral ***Age requirements must comply with Breast Diagnostic Enrollment Form***	G0204	$151.01	7
	G0204-TC	$108.85	
	G0204-26	$42.16	
Diagnostic mammogram, Digital, Unilateral ***Age requirements must comply with Breast Diagnostic Enrollment Form***	G0206	$118.84	7
	G0206-TC	$85.16	
	G0206-26	$33.68	
Radiological examination, surgical specimen (obtained during approved breast procedure)	76098	$17.66	
	76098-TC	$ 9.86	
	76098-26	$ 7.80	
Echography (Ultrasound), breast(s); unilateral or bilateral, B-scan and/or real time with image documentation ***Age requirements must comply with Breast Diagnostic Enrollment Form***	76645	$91.36	7
	76645-TC	$65.03	
	76645-26	$26.33	
Ultrasonic guidance for needle placement; Breast (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	76942	$68.43	
	76942-TC	$36.15	
	76942-26	$32.28	
Mammary ductogram or galactogram, single duct, radiologic supervision and interpretation	77053	$55.33	9
	77053-TC	$38.10	
	77053-26	$17.24	
Mammography, Diagnostic Follow-up, Unilateral ***Age requirements must comply with Breast Diagnostic Enrollment Form***	77055	$83.13	7
	77055-TC	$49.13	
	77055-26	$34.00	
Mammography, Diagnostic Follow-up, Bilateral ***Age requirements must comply with Breast Diagnostic Enrollment Form***	77056	$106.87	7
	77056-TC	$64.71	
	77056-26	$42.16	
Screening Mammogram, Bilateral (2 view film study of each breast); ***(patient must be age 40+)***	77057	$76.32	7
	77057-TC	$42.31	
	77057-26	$34.00	
Magnetic resonance imaging, breast, without and/or with contract material(s); unilateral Pre-approval required;	77058	$505.03	8
	77058-TC	$426.26	
	77058-26	$78.77	
Magnetic resonance imaging, breast, without and/or with contract material(s); bilateral	77059	$503.08	8
	77059-TC	$424.32	
	77059-26	$78.77	

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WOMEN' & MEN'S HEALTH PROGRAMS

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CERVICAL DIAGNOSTIC PROCEDURES			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**END NOTES**
Colposcopy of the cervix	57452	$101.67	
	57452 *	$86.74	
Colposcopy of the cervix, with biopsy(s) and endocervical curettage	57454	$143.70	
	57454 *	$128.77	
Colposcopy of the cervix, with biopsy(s)	57455	$133.30	
	57455 *	$105.07	
Colposcopy of the cervix, with endocervical curettage (not including Biopsy of Cervix)	57456	$126.10	
	57456 *	$97.86	
Endoscopy with loop electrode biopsy(s) of the cervix; *(allowable when in accordance with program guidelines-refer to Cervical Diagnostic Enrollment Form)*	57460	$261.83	10
	57460 *	$154.40	
Endoscopy with Loop electrode conization of the cervix; *(allowable when in accordance with program guidelines-refer to Cervical Diagnostic Enrollment Form)*	57461	$296.55	10
	57461 *	$178.09	
Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure) (RULE: This is allowable only if the Pap smear was abnormal (ASCUS, Low-grade SIL or CIN I, High-grade SIL or CINII/CINIII, or AGUS)	57500	$118.02	
	57500 *	$71.60	
Endocervical Curettage (not done as part of a dilation and curettage)	57505	$94.61	
	57505 *	$85.85	
Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser; *(allowable when in accordance with program guidelines-refer to Cervical Diagnostic Enrollment Form)*	57520	$284.69	10
	57520 *	$256.46	
Loop electrode excision procedure *(allowable when in accordance with program guidelines-refer to Cervical Diagnostic Enrollment Form)*	57522	$245.92	10
	57522 *	$228.40	
Endometrial Biopsy with or without endocervical sampling as follow-up for Atypical Glandular Cells (AGC) Pap Smear Results *(allowable when in accordance with program guidelines-refer to Cervical Diagnostic Enrollment Form)*	58100	$102.01	
	58100 *	$83.19	
Endometrial Biopsy with or without endocervical sampling as follow-up for Atypical Glandular Cells (AGC) Pap Smear Results *(allowable when in accordance with program guidelines-refer to Cervical Diagnostic Enrollment Form)*	58110	$45.16	
	58110 *	$38.99	

COLORECTAL CANCER SCREENING & DIAGNOSTIC PROCEDURES			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**END NOTES**
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) (ASC Group 2)	45378	$359.09	
	45378 *	$202.01	
	45378-53	$125.88	
	45378-53 *	$59.35	
Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	45380	$428.13	
	45380 *	$241.83	
Colonoscopy, with removal of tumor(s), polyp(s), or other lesion(s), by hot biopsy forceps or bipolar cautery (ASC Group 2)	45384	$428.11	
	45384 *	$252.86	
Colonoscopy, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique (ASC Group 2)	45385	$483.28	
	45385 *	$287.25	

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LABORATORY AND PATHOLOGY			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**END NOTES**
Venipuncture	36415	$3.00	13
Basic metabolic profile	80048	$11.54	
	80048QW	$11.54	
Comprehensive metabolic panel	80053	$14.41	
	80053QW	$14.41	
Lipid Panel	80061	$18.27	
	80061QW	$18.27	
Total Cholesterol	82465	$5.93	
	82465QW	$5.93	
Glucose quantitative	82947	$5.36	
	82947QW	$5.36	
Blood, regent strip	82948	$2.19	
Hemoglobin, glycosylated (A1c)(only for clients previously diagnosed with diabetes)	83036	$13.24	
	83036QW	$13.24	
HDL Cholesterol	83718	$11.17	
	83718QW	$11.17	
Papillomavirus, Human, Amplified Probe • Hybrid Capture II from Digene – HPV Test [High Risk Typing, only} • Cervista HPV HR	87621	$47.87	14
Cytopathology, Smears, (breast discharge or cervical smear only) Smears with interpretation	88104	$68.66	
	88104-TC	$40.37	
	88104-26	$28.30	
Cytopathology, Smears, (breast discharge or cervical smear only) filter method only with interpretation	88106	$77.44	
	88106-TC	$58.54	
	88106-26	$18.89	
Cytopathology, concentration technique, smears and interpretation (breast discharge or cervical smear only) (eg, Saccomanno technique)	88108	$72.48	
	88108-TC	$50.43	
	88108-26	$22.05	
Cytopathology (conventional Pap test), cervical or vaginal, any reporting system *requiring interpretation by physician.*	88141	$29.69	
Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	88142	$20.73	
Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	88143	$19.23	15
Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision	88164	$14.42	
Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision	88165	$14.42	
Evaluation of Fine Needle Aspirate; Breast, specimen Adequacy	88172	$51.25	
	88172-TC	$16.35	
	88172-26	$34.90	
Evaluation of Fine Needle Aspirate; Breast, interpretation and report	88173	$136.74	
	88173-TC	$67.63	
	88173-26	$69.11	

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LABORATORY AND PATHOLOGY- CONTINUED			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**END NOTES**
Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	88174	$20.73	15
Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision	88175	$20.73	15
Surgical Pathology, gross examination only (surgical specimen)	88300	$13.17	13
	88300-TC	$ 8.89	
	88300-26	$ 4.29	
Surgical Pathology, gross and microscopic examination (review level II)	88302	$27.30	13
	88302-TC	$20.57	
	88302-26	$ 6.73	
Surgical Pathology, gross and microscopic examination (review level III)	88304	$39.61	13
	88304-TC	$28.68	
	88304-26	$10.92	
Surgical Pathology, gross and microscopic examination (review level IV)	88305	$66.06	13
	88305-TC	$29.01	
	88305-26	$37.05	
Surgical Pathology, gross and microscopic examination (review level V)	88307	$265.61	13
	88307-TC	$184.79	
	88307-26	$80.82	
Surgical Pathology, gross and microscopic examination (review level VI)	88309	$404.79	13
	88309-TC	$261.96	
	88309-26	$142.83	
Pathology consultation during surgery	88329	$53.38	13
	88329 *	$34.55	
Pathology consultation during surgery, first tissue block, with frozen section(s)	88331	$93.18	13
	88331-TC	$32.58	
	88331-26	$60.60	
Pathology consultation during surgery, first tissue block, with frozen section(s), each additional specimen	88332	$41.18	13
	88332-TC	$11.16	
	88332-26	$30.02	
Immunohistochemistry – SEE G0461 & G0462	88342	--	16
Immunohistochemistry or immunocytochemistry, per specimen; first single or multiplex antibody stain	G0461	$81.58	16
	G0461-TC	$52.05	
	G0461-26	$29.53	
Immunohistochemistry or immunocytochemistry, per specimen; each additional single or multiplex antibody stain (list separately in addition to code for primary procedure)	G0462	$62.39	16
	G0462-TC	$50.43	
	G0462-26	$11.97	

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LAB CHARGES RELATED TO PRE-OPERATIVE VISIT PRE-APPROVAL REQUIRED FOR EACH CLIENT

NOTE:

- Only allowable with pre-approval and should be medically necessary for the planned surgical procedure.
- Will only be reviewed for program allowable procedures.
- Other pre-operative tests not listed below can be considered for reimbursement during the pre-approval process.

DESCRIPTION OF SERVICES	CPT Codes	Program Rates	END NOTES
Basic metabolic panel (calcium, total). This panel must include the following: calcium, total (82310), carbon dioxide (82374), creatinine (82565), glucose (82947), potassium (84132), sodium (84295).	80048	$11.54	9
	80048 QW	$11.54	
Comprehensive metabolic panel. This panel must include the following: albumin (82040); bilirubin, total (82247); calcium (82310); carbon dioxide (bicarbonate) (82374); chloride (82435); creatinine (82565); glucose (82947); phosphatase, alkaline (84075); potassium (84132); protein, total (84155); sodium (84295); transferase, alanine amino (84460); transferase, aspartate amino (84450); urea nitrogen (84520)	80053	$14.41	9
	80053 QW	$14.41	
Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	85025	$6.34	9
Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	85027	$8.83	9
Prothrombin time	85610	$5.37	9
	85610 QW	$5.37	
Thromboplastin time, partial (PTT); plasma or whole blood	85730	$8.19	9

HOSPITAL - ANESTHESIA – AMBULATORY SURGERY CENTERS

DESCRIPTION OF SERVICES	CPT Codes	Program Rates	END NOTES
Hospital Fees related to approved Breast, Cervical and Colon Procedures	00300	Medicaid % Rate	17
Anesthesia during approved Breast Procedures	00400	Attachment 1	
Anesthesia during approved Colon Procedures	00800	Attachment 1	
Anesthesia during approved Colon Procedures	00810	Attachment 1	
Anesthesia during approved Cervical Procedures	00940	Attachment 1	
Ambulatory Surgery Centers related to approved Breast or Colon Procedures (NOTE: Refer to Procedure Code for ASC Group Assignment)	Group 1	$349.00	18
	Group 2	$466.00	
	Group 3	$538.00	

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END NOTES	
1	State Pap Plus Program
2	Program allowed limit same as CPT 99203
3	Program allowed limit same as CPT 99213
4	Program allowed limit same as CPT 99395
5	CPT Codes 19081-19086 are to be used for breast biopsies that include image guidance, placement of localization device, and imaging of specimen. These codes should not be used in conjunction with 19281-19288.
6	CPT Codes 19281-19288 are for image guidance placement of localization device without image-guided biopsy. These codes should not be used in conjunction with 19081-19086.
7	Age requirements must comply with Breast Diagnostic Enrollment Form (See Policy Page 10B-4 for 18-39 years of age)
8	Breast MRI is allowed under certain circumstances; pre-approval for these procedures must be obtained.
9	Prior approval by Program
10	A LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations; must comply with Cervical Diagnostic Enrollment Form.
11	G0105 may be used for screening colonoscopy on clients considered to be at increased risk for CRC due to a family history of CRC or adenomatous polyps. The Medicare definition of high risk includes both those considered to be an increased risk (personal or family history of CRC or adenomatous polyps) or high risk (family history of FAP or Lynch Syndrome or personal history of inflammatory bowel disease) as defined by CRCCP policies and procedures.
12	G0106 (colorectal cancer screening; barium enema; as an alternative to G0104; screening sigmoidoscopy), G0120 (colorectal cancer screening; barium enema; as an alternative to G0105; screening colonoscopy), and G0122 (colorectal cancer screening; barium enema) are not included as barium enema is no longer recommended by USPSTF as a colorectal cancer screening test. Double contract barium enema may still be used as a diagnostic test to evaluate an abnormal FIT or FOBT (NOTE: Colonoscopy is the preferred test in this circumstance)
13	Only allowable when samples collected during covered procedures
14	HPV DNA testing is a reimbursable procedure if used for screening in conjunction with Pap testing or for follow-up of an abnormal Pap result or surveillance as per ASCCP guidelines. It is not reimbursable as a primary screening test for women of all ages or as an adjunctive screening test to the Pap for women under 30 years of age. Providers should specify the high-risk HPV DNA panel only. Reimbursement of screening for low-risk HPV types is not permitted. Cervista HPV HR is reimbursable at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay. Genotyping (e.g., Cervista HPV 16/18) is not allowed.
15	Program allowed limit same APPLICABLE 88142 Medicare reimbursement rate (or less)
16	CPT 88342 (Immunohistochemistry) replaced by G0461 (first slide) and G0462 (each additional slide); these codes are only payable for samples collected during a covered breast, or cervical procedure for diagnostic purposes.
17	Allowable costs related to a breast, cervical or colon procedure, not shown on the fee schedule as a "Technical Fee" will be bundled together and shown on the billing authorization using CPT 00300. This code will be paid at the Hospital's approved Medicaid % rate. Hospitals are required to provide a copy of their approved Nebraska Medicaid Rate Letter each time the rate is modified.
18	ASC bills for the facility fee using the same procedure code as the professional service and attaching a modifier –SG. The modifier indicates that the claim is for the facility fee ONLY. Clients receiving more than one approved service at an ASC facility on the same date; the full rate will be applied to the first service and additional services will be reimbursed at 50%.

ADDITIONAL PROGRAM NOTES
77051 and 77052 (CAD) are not allowable codes under the National Breast and Cervical Cancer Early Detection Program; these codes will show as "Not Covered" on Billing Authorizations. Providers should discuss these charges with program participants and give them the option to waive the CAD or write-off these charges.
76499 Unlisted diagnostic radiography procedure (3D Mammography) is not allowed under the National Breast and Cervical Cancer Early Detection Program. Providers should discuss these charges with program participants and give them the option to waive the additional 3D services or write-off these charges.

* THESE AMOUNTS APPLY WHEN SERVICE IS PERFORMED IN A FACILITY SETTING – for the purpose of this program, "Facility" includes hospitals and ambulatory surgical centers (ASCs). Rates listed for services include all incidental charges related to the procedure; additional amounts may not be billed to the client.

TC = Technical Component 26 = Professional Component CF = Conversion Factor QW = CLIA Certificate of Waiver

WOMEN' & MEN'S HEALTH PROGRAMS

Fee for Service Schedule – REVISED 10-2014

Effective July 1, 2014 through June 30, 2015

REVISED rates are in RED

Attachment 1: Anesthesia Rates effective 7/1/2014 through 6/30/2015

Fee Schedule for Anesthesia is based on Medicaid Reimbursement system with unit values rounded to nearest cent. Rates are adjusted annually with the Program's Fiscal Year which runs July 1 through June 30.

Anesthesia Claims Modifiers:

Healthcare providers report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed or medically supervised. All claims for anesthesia services must include:

- CPT Code with Modifier (see list below)
- Start & Stop Times
- Explanation of Benefits from Primary Insurance (where applicable)

When a physician bills for anesthesia services, the correct procedure code AND modifiers indicate:

- The Physician personally provided services to the individual patient
- The physician provided medical direction for CRNA services and the number of concurrent services directed.

The following modifiers MUST be used by when submitting claims for anesthesia services:

AA – Anesthesia Services performed personally by the anesthesiologist
AD – Medical Supervision by a physician; more than 4 concurrent anesthesia procedures
QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QX – RNA service; with medical direction by a physician
QY – Medical direction of one certified registered nurse anesthetist by an anesthesiologist
QZ – CRNA service; without medical direction by a physician

Fee Schedule:

To determine the allowable rate for anesthesia services, add the unit value for the procedure to the number of minutes for the procedure and multiple by the appropriate conversion factor.

(Unit Value + Minutes) x Conversion Factor = Allowable Rate

Unit Value:

CPT Code	AA/QY	QK	QX	QZ
00400*	$44.88	$67.87	$44.58	$44.79
00800*	$44.88	$67.87	$44.58	$44.79
00810*	$74.80	$113.12	$74.30	$74.65
00940*	$44.88	$67.87	$44.58	$44.79

*Anesthesia only covered when the surgical procedure performed is determined to be payable.

Minutes:
Anesthesia claims must include Start and Stop Times of the Procedure.

Conversion Factors: AA = $1.73 QX = $0.81
QY = $1.73 QZ = $1.43
QK = $0.86

(EXAMPLE: CPT 00400-QZ – 68minutes … ($44.79 + 68) x $1.43 = $161.29)

* THESE AMOUNTS APPLY WHEN SERVICE IS PERFORMED IN A FACILITY SETTING – for the purpose of this program, "Facility" includes hospitals and ambulatory surgical centers (ASCs). Rates listed for services include all incidental charges related to the procedure; additional amounts may not be billed to the client.

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